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NATO USA
CIRCULAR LETTERS

JAN. - FEB. 1944

MEMO FOR RECORD

(Do not detach from file)

This file item, or portions thereof as indicated below, has been indexed for inclusion in Departmental Records Branch Describable Item Index:

DATE	INDEXER
8 July 1953	Catherine Mowrey

Ub4699

TAGO FORM 01352 *(Formerly AGO)*
1 FEB 49

File

Surg AMG

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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

16 February 1944

CIRCULAR LETTER NO. 11

I - CORRESPONDENCE ON TECHNICAL MATTERS.

It has been noted on a number of occasions recently that direct correspondence on technical matters has been had with agencies of the War Department without reference to this office. It is desired that this practice be discontinued and that all such correspondence be submitted through technical channels.

II - SAFEGUARDING OF NARCOTICS AND ALCOHOLICS.

1. It has come to the attention of this office that Medical Department narcotics were found in illicit traffic in this theater.

2. It is highly important that narcotics be safeguarded so that such incidents do not occur. Responsible officers will, in addition to complying with paragraph 17 a (2), AR 40-990, and paragraph 6 c, AR 40-1705, institute control measures within wards by periodic inspections and records to insure the proper expenditure of narcotics and alcoholics.

III -- IMPROVING OPERATION OF BUNSEN BURNER.

Item No. 94060, BURNER, BUNSEN, ALCOHOL: It has been found by laboratories in the theater that this item functions much better if the wire screen is removed.

3732

IV - TYPHUS VACCINE.

It is desired to invite the attention of all concerned to the fact that the typhus vaccine being currently distributed contains some egg protein which may precipitate in storage. This is entirely normal, and does not interfere with the effectiveness of the vaccine or create any danger which would contra-indicate its use.

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To prepare the vaccine for use, shake it for three minutes and then allow the precipitate to settle out and use the supernatant fluid. Small suspended particles that will pass through a Luer needle are not considered harmful in this type of vaccine.

V - INTRAVENOUS SOLUTIONS.

1. It has come to the attention of this office that Item 14623, SULFADIAZINE SODIUM, USP, 5 GM VIAL: (for intravenous use), contains a certain amount of insoluble material. At the present time it is impossible to manufacture a product that will not form insoluble crystals in storage. The presence of crystals does not indicate product is unsatisfactory and when such products are present, reasonable handling will allow drawing off the supernatant fluid which can then be used for intravenous administration.

2. A report of any intravenous solutions which are found to contain pyrogens, or which for any reason are found unfit for human use, will be forwarded to Surgeon, N.A.T.O.U.S., through technical channels, with an indication of the manufacturer, Lot No., date of manufacture, and a full report of the deficiency found.

VI - REMOVAL OF ITEM 91211, SULFANILAMIDE, CRYSTALLINE, FROM MEDICAL DEPARTMENT KITS

Circular Letter No. 40, this office, dated 22 October 1943 is amended by deleting: Item 97765, KIT, FIRST AID, AERONAUTIC, from paragraph 1. Item 91211, SULFANILAMIDE, CRYSTALLINE, USP, 5 GRAMS: in Sterile Individual Double Wrapped Envelope, is now being included as a component of Item 97765.

VII - TENTATIVE CHANGES IN TABLES OF EQUIPMENT.

1. Letter Headquarters N.A.T.O.U.S., File AG 414.5/357 D-O, dated 22 January 1943, Subject: Flashlights, to CG. SOS, N.A.T.O.U.S., tentatively amends Signal Equipment Section of Tables of Equipment within this theater to provide flashlights, TL-122-A, to Station and General Hospitals in quantities as listed below, on the basis of one per Officer, Nurse, Dietitian, Physical Therapy Aide and Motor Vehicle.

STATION HOSPITAL (250 BED) T/E 8-560 (250 BED) 28 December 1943
Additional flashlights authorized - 25 (Total now 55)

STATION HOSPITAL (500 BED) T/E 8-560 (500 BED) 5 January 1943
Additional flashlights authorized - 56 (Total now 102)

STATION HOSPITAL (750 BED) T/E 8-560 (750 BED) 2 January 1943
Additional flashlights authorized - 83 (Total now 139)

GENERAL HOSPITAL (1000 BED) T/E 8-550 (1000 BED) 19 March 1943
Additional flashlights authorized - 110 (Total now 184)

2. Letter Headquarters N.T.O.U.S.A. to CG, SOS, NATOUSA, file AG 440/366 SURG-O, dated 25 January 1944, Subject: Changes in T/BA and T/E for Infantry Divisions, authorizes the following:

NORTHERN COMBAT DIVISION, INFANTRY DIVISION T/O & E 5-15 dated 15 July 1943

DIVISION ARTILLERY, INFANTRY OR MOTORIZED DIVISION T/O & E 6-10 dated 15 July 1943

34042	OTOSCOPE:	En One per Med. Det.
97370	ANEMOMETER, (ANEROID):	En One per Med. Det.

VIII - TENTATIVE CHANGES IN MEDICAL DEPARTMENT EQUIPMENT LISTS.

1. The following tentative changes in Medical Department Equipment Lists are authorized and published herein for the information and guidance of all concerned. The following items are tentatively authorized in addition to present allowances:

a. CONVALESCENT HOSPITAL, CZ, (3000-BED) T/E 8-590, 1 April 1942
(Med. Dept. Equip. List No. 97215 dated 1 June 1943)

99387	MACHINE, EMBOSSING:	En	3

b. GENERAL HOSPITAL, CZ, (1000-BED) T/E 8-550, 19 March 1943
(Med. Dept. Equip. List No. 97235 dated 1 May 1943)

42335	ANEMOCHRONOMETER, PHOTOELECTRIC, DIRECT READING:	En	1
43470	MICROTOME, ENTIRE, HOME:	En	1
73740	SUIT, CONVALESCENT, COAT:	En	400
73750	SUIT, CONVALESCENT, TROUSERS:	En	400
99387	MACHINE, EMBOSSING:	En	3

c: EVACUATION HOSPITAL, (750-BED) T/E 8-580, 23 April 1943
(Med. Dept. Equip. List No. 97225 dated 16 July 1943)

30900	CASE, TRIAL LENSES, COMPLETE:	En	1
38794	VISION TEST APPARATUS, PORTABLE:	En	1
43730	PIPETTE, SEROLOGICAL, 1 CC:	En	30
73670	PILOT, FLAME:	En	150
99387	MACHINE, EMBOSSING:	En	3

d. EVACUATION HOSPITAL, SEMI-MOBILE, (400-BED) T/E 8-581, 26 July 1943
(Med. Dept. Equip. List No. 97225 dated 1 June 1943

30900	CASE, TRIAL LENSES, COMPLETE:	En	1
38794	VISION TEST APPARATUS, PORTABLE:	En	1
43150	MICROSCOPE:	En	1
43730	PIPETTE, SEROLOGICAL, 1 CC:	En	30
99387	MACHINE, EMBOSSING: (Total Now 5)	En	1

3731

e. STATION HOSPITAL, CZ, (750-BED) T/E 8-560, 2 January 1943
(Med. Dept. Equip. List No. 97325 dated 10 May 1943)

1.2835 HEMOGLOBINOMETER, PHOTOELECTRIC, DIRECT READING: Ea 1

f. STATION HOSPITAL, CZ, (500-BED) T/E 8-560, 5 January 1943
(Med. Dept. Equip. List No. 97323 dated 10 May 1943)

1.2835 HEMOGLOBINOMETER, PHOTOELECTRIC, DIRECT READING: Ea 1
99387 MACHINE, IMPRINTING: Ea 2

g. STATION HOSPITAL, CZ, (250-BED) T/E 8-560, 26 December 1943
(Med. Dept. Equip. List No. 97320 dated 15 May 1943)

99387 MACHINE, IMPRINTING: Ea 2

h. GENERAL DISPENSARY, CZ, T/E 8-650, 14 November 1942.
(Med. Dept. Equip. List No. 97230 dated 15 July 1943)

99387 MACHINE, IMPRINTING: Ea 2

i. MEDICAL MAINTENANCE UNIT, 12 February 1943.

99387 MACHINE, IMPRINTING: (Total Now 2) Ea 1

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

DISTRIBUTION:
All Medical Installations
Surgeon, ABS - 200
Surgeon, IBS - 200
Surgeon, CD IBS - 50
Surgeon, EBS - 500
Surgeon, IBS - 75
Surgeon, NORBS - 50
Surgeon, PBS - 500
Surgeon, Fifth Army - 800
Surgeon, Seventh Army - 300
Surgeon, AAF ETO - 50
Surgeon, AAFSC ETO - 200
Surgeon, 12th Air Force - 300
Surgeon, 15th Air Force - 300
Surgeon, Hq. Command, AF - 50
Surgeon, AMG - 25
Surgeon, NATOUSA - 250
AG NATOUSA - 50

ACC-DIST
HQ COMDT - MAIN - (2)
HQ COMDT - REAR - (2)
Regt to 6,849 - 2 each
Surg 5th Army - 2
Surg 6th Army - 2
Field - 1

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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

15 February 1944

CIRCULAR LETTER NO. 10

I - VESICANT CHEMICAL CASUALTIES: Second sentence, paragraph 3a, Appendix I, Circular Letter No. 5, 20 January 1944, is amended to read: "Protective ointment then should be used as for other vesicant agents".

II - HOSPITAL DISPOSITION BOARDS: Paragraph 5 b (4), Circular Letter No. 8, 8 Jan. 44, is amended to read as follows: "(4) One true copy of all reports of proceedings on Medical Department officers to be forwarded through technical channels to the Surgeon NATOUSA, APO 534".

III - RELAPSING MALARIA.

1. Experience has shown that despite various treatment regimes malaria is a disease prone to relapse, especially when the infection is caused entirely or in part by Plasmodin vivax. This letter deals with treatment of relapses and disposition of malaria patients to the Zone of the Interior.

2. First and second relapses of malaria should be treated like a primary attack, using the system of therapy outlined in Section II, par. a (1), Circular Letter No. 34, Office of the Surgeon, Hq. NATOUSA., dated 14 September 1943.

3. Third and subsequent relapses should be treated with quinine according to the following 10-day regime:

a. Quinine sulfate 1.0 gram (15 grains) by mouth three times daily after meals for the first three days.

b. Quinine sulfate 0.32 gram (5 grains) by mouth three times daily after meals for the next seven days.

4. The use of adrenalin followed by atabrine or quinine (so-called Ascoli method) is not recommended because its value has not been demonstrated.

Acc-Dist
HQ Comdt-Main — 2
HQ Comdt-Rear — 2
Reg't to 6, 8, 9 — 2
Army-5 Army — 3
Army-8 Army — 3/26

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5. Every method of adjuvant therapy should be employed as indicated to restore the physical condition of malaria patients. Of special value are:

a. High caloric, high meat protein diets.

b. Multivitamin pills or capsules.

c. Transfusion when patient is very anemic.

d. Ferrous sulfate in appropriate doses.

6. It is not logical to set up absolute criteria for disposition to the Zone of Interior of personnel who have had one or more attacks of malaria. Some patients are in better physical condition after several relapses than other patients after a primary attack. Patients who develop chronic malarial cachexia, persistent splenomegaly, or recalcitrant anemia should be considered as subjects for evacuation to the Zone of the Interior.

For the SURGEON:

E. STANDISH,
Colonel, M.C.,
Deputy Surgeon.

DISTRIBUTION:
All Medical Installations

Surgeon, ABS	- 200
Surgeon, NBS	- 200
Surgeon, CD MBS	- 50
Surgeon, EBS	- 500
Surgeon, IBS	- 75
Surgeon, NORBS	- 50
Surgeon, PBS	- 500
Surgeon, Fifth Army	- 800
Surgeon, Seventh Army	- 700
Surgeon, AAF MTO	- 50
Surgeon, AAFSC MTO	- 200
Surgeon, 12th Air Force	- 300
Surgeon, 15th Air Force	- 300
Surgeon, Hq. Command, AF	- 50
Surgeon, AMG	- 25
Surgeon, NATOUSA	- 250
AC NATOUSA	- 50

File.
2843

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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

31 January 1944

CIRCULAR LETTER NO. 9

SUBJECT: Hospital Funds

1. Hospital commanders will receive, disburse and account for all moneys pertaining to their hospital, accruing from authorized sources in one fund, a hospital fund, in conformity with provisions of AR 210-50, dated 29 Dec. 1942, as amended.

2. Retained duplicate statements of the hospital fund (WD MD Form 49) will constitute the council book.

3. Hospital funds will be utilized to the fullest extent possible in providing additional comforts and recreational facilities for patients and enlisted duty personnel in hospitals.

4. In order to protect the hospital fund from adverse criticism and to maintain its integrity as an important adjunct to the operation of hospitals, the basic object of the fund will be carefully observed. The general recommendations of the hospital fund council and the approval of the commanding officer will guide the custodian in complying strictly with the letter and spirit of the regulations governing this fund.

5. Moneys received for subsistence from officers of the U. S. Navy, Marine Corps, Coast Guard, Public Health Service and Civilians in hospitals under the provision of paragraph 4, Section I, Circular No. 230, NATOUSA, dated 26 November 1943 will be taken up in the hospital fund under "Cash received from other sources" and disbursed to the Sales Officer under "Miscellaneous Expenditures". This transaction will be supported by proper vouchers

6. Durable property, which has been lost, damaged or destroyed through fair wear and tear, will be dropped on the Returns of Durable Property at the end of the month during which disposition occurred and such disposal will be supported by appropriate certificate, approved by the hospital council.

3730

7. Proceedings of the council of the hospital fund will be recorded on retained duplicate statements only of the hospital fund (WD MD Form 49) in conformity with paragraph 19, AR 210-50

2 Copies to Hq Comd'g
for Med. Officer

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8. Original hospital fund statements will be forwarded through technical channels to the Surgeon, NATOUSA, within five days after audit.

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

DISTRIBUTION:

Surgeon ABS	-	25
Surgeon IBS	-	50
Surgeon EBS	-	50
Surgeon IBS	-	25
Surgeon PBS	-	60
Surgeon NORBS	-	25
Surgeon CD 2BS	-	10
Surgeon 5th Army	-	50
Surgeon AAFSC ETO	-	60
Surgeon 7th Army	-	5
Surgeon Hq Comd	-	5
Surgeon AMG	-	5
Surgeon NATOUSA	-	100
AG NATOUSA	-	50

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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

Surg AMG File 2418

30 January 1944

CIRCULAR LETTER NO. 6

SUBJECT: Hospital Disposition Boards

1. General. During the past year, approximately seven percent of all admissions to hospital in this theater have been evacuated to the United States as a result of recommendations of medical disposition boards. While this percentage may not appear to be large, the aggregate number evacuated exceeds the total personnel of an infantry division by a substantial number. The effect of the loss of this number of trained personnel and the problems of their replacement is reflected in the efficiency of every unit in this theater.

2. Composition.

a. Hospital disposition boards are formed by the authority of, and in conformity with, the provisions of par. 7, AR 40-590. The minimum number of three officers comprising the board should be the senior officers of the medical and surgical services respectively, and a third officer, Medical Corps, of field grade. In addition, a company grade officer, Medical Corps, may be appointed at the discretion of the hospital commander and serve as recorder of the board. It is considered of benefit if one member of the board has performed field service in this theater.

b. Ordinarily, members of a disposition board should not present a patient for disposition.

3. Functions.

a. It is the duty of hospital disposition boards to make recommendations as to the disposition of such patients as may be brought before them, after careful study of the patients and their records. The recommended disposition must conform to alternatives set forth in NATOUSA Circulars, as follows:

(1) In the case of enlisted men:

3729

(a) Par. 3 a, Sec. II, NATOUSA Circular 215, dated 6 Nov. 1943.

(2) In the case of officers:

(a) Par. 5, Sec. II, NATOUSA Circular 161, dated 15 Sept. 1943.

b. Members of hospital disposition boards will familiarize themselves with the rules of procedure governing such boards and pertinent regulations and publications as follows:

(1) Article of War 107.

(2) Army Regulations 35-1440; 40-105, 40-590, and 40-1025; 345-415; 420-5; 605-230; section II, c4, c12 and section VIII, c8, 615-360.

(3) W.D. Circular 293, dated 11 Nov. 1943.

(4) Mobilization Regulations 1-9 and current changes thereto.

(5) NATOUSA Circulars, 1943, Sec. III, No. 139, Sec. 1 and II 155, Sec. 1 No. 163, Sec. II, No. 215, and Sec. III, No. 200.

4. General Conduct of Disposition Boards.

a. It is the major responsibility of hospital disposition boards to return every possible officer and enlisted man to duty, and, second, to recommend retention of every man within the theater who is believed capable of performing useful duty. Board members must familiarize themselves with the problems and capabilities of personnel centers in order that proper decisions can be made.

b. Discussion as to recommended dispositions should not be carried on, at any time, within the hearing of patients, nor should the recommendations of a disposition board be announced to a patient until such time as the recommendations of the board are approved by the hospital commander. Previous conditioning of patients in respect to the possibilities of "other than general duty" assignments or evacuation to the Zone of the Interior, caused by indiscriminate discussion of patients' capabilities in their hearing, increases the difficulties faced by disposition boards in respect to a proper recommendation. Strict adherence to this principle by all members of hospital staffs would have a marked influence in increasing the number of patients returning to general duty.

c. Hospital disposition boards should not review the status of members of their own unit, particularly officer personnel. Such personnel should appear before a disposition board of another hospital whenever there is a possibility that they may be evacuated to the Zone of the Interior.

5. Reboarding.

a. Patients will be reboarded under the following circumstances:

(1) If action on the recommendations of a disposition board is delayed beyond a reasonable period and, in the opinion of the ward officer and the chief of the service concerned, the status of the patient has changed.

(2) If, upon transfer of a patient, the chief of the service concerned, in the hospital to which the patient is transferred, does not agree with previous board findings and recommendations. In such cases patients will not be reboarded without a proper period of observation.

6. Conduct and Reports of Proceedings.

a. The conduct of hospital disposition boards will conform in general with the provisions of Section I, AR 420-5.

b. Reports of proceedings will conform with the sample form, attached. A minimum number of true copies of reports will be made to furnish the following:

(1) Original to form a part of the patient's medical record.

(2) One true copy to be filed at the hospital boarding the patient.

(3) One true copy to be retained in Base Section where final disposition of the patient is made.

(4) One true copy of all reports of proceedings held on medical officers to be forwarded through technical channels to the Surgeon, NATOUSA.

c. Upon transfer of patients who have been boarded, the report of proceedings will be sealed in an envelope together with such other records required to be sealed in conformity with Circulars, Office of the Surgeon, NATOUSA.

For the SURGEON:

E. STANDLEE
Colonel, M.C.,
Deputy Surgeon.

1 Incl:- Form for Board Proceedings

DISTRIBUTION:

To all hospitals		
Surgeon ABS	-	25
Surgeon NBS	-	50
Surgeon EBS	-	50
Surgeon IBS	-	25
Surgeon PBS	-	60
Surgeon NCBNS	-	25
Surgeon CD Res	-	10
Surgeon 5th Army	-	50
Surgeon AAFSC MTO	-	60
Surgeon 7th Army	-	5
Surgeon Hq Comd	-	5
Surgeon AnG	-	5
Surgeon NATOUSA	-	100
AG NATOUSA	-	50

Hist: A G (Pers)
G-1
Med O.
Hq Comd
File

3728

_____HOSPITAL
APO ____

Proceedings of a board of Medical Officers convened at ___ _____Hospital, ___, pursuant to paragraph ___, SO ___, Hq. ___ _____Hospital, date _____

DETAIL FOR THE BOARD

The Board met at ___ _____ Hospital, APO ___ _____(Date)_____

All members present *except:

The Board then proceeded with the examination of: (Specify name, rank or grade, serial number, organization, length of service, age).

Length of Service: Age:

Who was admitted to ___ _____ Hospital _____(Date)_____ under the following circumstances:

Brief medical history of the case:

After a thorough examination of the patient and his clinical records, the Board finds that the diagnosis is as follows: (List separately, with cause, degree of severity, and LD of each).

LD: _____

The Board recommends that the patient be classified as _____ and :

_____ (name) President

_____ (name) Member

_____ (name) Member

_____ (name) Member and Recorder

Evacuation classification:

Battle Casualty: *Yes No

5727

The Board then proceeded with the examination of: (Specify name, rank or grade, serial number, organization, length of service, age).

Length of Service: Age:

Who was admitted to ___ _____ Hospital _____(Date)_____ under the following circumstances:

Brief medical history of the case:

After a thorough examination of the patient and his clinical records, the Board finds that the diagnosis is as follows: (List separately, with cause, degree of severity, and LD of each).

LD: _____

The Board recommends that the patient be classified as _____ and :

_____ (name) President

_____ (name) Member

3727

_____ (name) Member

_____ (name) Member and Recorder

Evacuation classification:

Group _____ Sub-group

Battle Casualty: *Yes No

Approved:

(Date)_____ 19

_____

_____, M.C. Commanding

* Strike out inapplicable word.

It is recommended that this form be reproduced on legal size paper.

Surgeon
AMGOT

1945

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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

22 January 1944

CIRCULAR LETTER NO. 7

Tentative Changes in Medical Department Equipment Lists

CONVALESCENT HOSPITAL, CZ, (3000 BED) I
EVACUATION HOSPITAL, (750 BED) II
EVACUATION HOSPITAL, SEMIMOBILE, (400 BED) III
STATION HOSPITAL, CZ, (250 BED) IV

The following tentative changes in Medical Department Equipment lists are authorized and published herein for the information and guidance of all concerned.

I CONVALESCENT HOSPITAL, CZ, (3000 BED) T/E 8-590 - 1 April 1942.
(Med. Dept. Equip. List No. 97215 dated 1 June 1943)

Basic Equipment Lists of Convalescent Hospitals, CZ, (3000 Bed) are tentatively authorized to include the following item in addition to present allowances:

43170	MICROSCOPE, DARK FIELD, APPARATUS:	Ea	1

II EVACUATION HOSPITAL (750 BED) T/E 8-580 - 23 April 1943.
(Med. Dept. Equipment List No. 97225 dated 16 July 1943)

Basic Equipment Lists of Evacuation Hospitals (750 Bed) are authorized to include the following items in addition to present allowances, when considered necessary by the Surgeon of the Headquarters under which they operate:

70060	BED, ADJUSTABLE:	Ea	10
71607	MATTRESSES, INNER-SPRING:	Ea	10

III EVACUATION HOSPITAL, SEMIMOBILE, (400 Bed) T/E 8-581 - 26 July 1943.
(Med. Dept. Equipment List No. 97223 dated 1 June 1943)

Basic Equipment Lists of Evacuation Hospitals, Semimobile (400 Bed) are authorized to include the following items in addition to present allowances, when considered necessary by the Surgeon of the Headquarters under which they operate:

70060	BED, ADJUSTABLE:	Ea	10
71607	MATTRESSES, INNER-SPRING:	Ea	10

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IV STATION HOSPITAL, CZ, (250 BED) T/E 8-560 - 28 December 1942.
(Med. Dept. Equip. List No. 97320 dated 15 May 1943)

Basic Equipment lists of Station Hospital, CZ, (250 Bed) are authorized to include the following items in addition to present allowances:

71770	TOWEL, BATH:	Ea	1000
71780	TOWEL, HAND:	Ea	2000
96055	X-RAY FIELD UNIT, LOADING BIN COMBINATION:	Ea	1

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

Surgeon, EDS - 400
Surgeon, MDS - 300
Surgeon, ABS - 150
Surgeon, IBS - 100
Surgeon, PBS - 500
Surgeon, NORBS - 100
Surgeon, AMGOT - 25
Surgeon, CD MBS - 30
Surgeon, Fifth Army - 600
Surgeon, Hq. Command, AF - 50
Surgeon, NATOUSA - 200
Surgeon, AAF, MTO - 50
Surgeon, Twelfth Air Force - 300
Surgeon, Fifteenth Air Force - 300
Surgeon, AAFSC, MTC - 200
Surgeon, Seventh Army - 350

Dist:
Chief - 1
Med Hq - 2
Hq Comdt - 1
AG - 1
Reg I - 3
Reg II - 3
Reg III - 3
Depots - 11

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1771.

HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

File

21 January 1944

CIRCULAR LETTER NO. 6

I - DENTAL SERVICE FOR UNITS THAT HAVE NO DENTAL OFFICER ASSIGNED.

It is the responsibility of the surgeon of any command, to which no dental officer is assigned, to secure dental treatment for his organization. This may be accomplished by an informal arrangement with an adjacent unit having dental personnel or by contacting the Surgeon of the base section in which the unit is located. In the latter case the Surgeon should designate a unit to provide the necessary dental care and should so inform the unit designated. When the dental service of an organization has been so designated it should make a careful survey of the unit in question and proceed in a systematic manner to accomplish the necessary work revealed.

II - RECORDS OF DENTURES AND SPECTACLE PRESCRIPTIONS.

Attention is invited to Change 17 of AR 345-125 dated 13 August 1943.

1. DENTURES AND OTHER DENTAL APPLIANCES.

a. This change requires a brief description of dentures and other dental prosthetic appliances, with date of issue, as an entry in the service record of the soldier concerned.

b. Each dental clinic upon the completion and insertion of a dental prosthetic appliance should forward to the organization commander concerned the required data for this entry.

2. SPECTACLE PRESCRIPTIONS.

3725

a. Spectacle prescriptions and date of issue of spectacles are required for insertion in the service record of the soldier concerned.

b. Medical Officers prescribing spectacles for individuals will forward the necessary data to the organization commander concerned, immediately upon issue of the spectacles.

Dist: AG Comdt (2)
A-G
Reg I (3)
Reg II (3)
File (16)

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III - TREATMENT OF VENEREAL DISEASE IN ARMY HOSPITALS.

1. The hospital management of patients with venereal disease ordinarily entails the use of diagnostic, epidemiological, and administrative procedures which are similar regardless of the specific type of venereal disease.

2. In order to insure that these functions are well coordinated the organizational charts for station and general hospitals will provide for a Venereal Disease Section.

3. Since ordinarily each of the venereal diseases is now effectively treated by internal medication, making surgical or manipulative procedures rarely necessary, the Venereal Disease Section should be organized as a unit of the Medical rather than the Surgical Service. In hospitals under construction and subsequently authorized, the staff organization will conform initially to this policy; in existing hospitals where the Venereal Disease Section is not already a unit of the Medical Service, it will be transferred thereto, unless, because of local conditions, such transfer would clearly be prejudicial to the most efficient care of patients with venereal disease.

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

DISTRIBUTION:

Surgeon, EBS	- 400
Surgeon, MBS	- 300
Surgeon, ABS	- 150
Surgeon, IBS	- 100
Surgeon, PBS	- 500
Surgeon, NORBS	- 100
Surgeon, AMGOT	- 25
Surgeon, CD LBS	- 50
Surgeon, 5th Army	- 600
Surgeon, 7th Army	- 350
Surgeon, AAF, MTO	- 50
Surgeon, 12th Air Force	- 300
Surgeon, 15th Air Force	- 300
Surgeon, AAFSC, MTO	- 200
Surgeon, Hq. Command, AF	- 50
Surgeon, NATOUSA	- 200

Distrib. Ex Officio 1
Med Off. 2
Adj. 2
Hqt Comd 1
Reg 1 3
Reg 2 3
Tulsa 3

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H E A D Q U A R T E R S
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

20 January 1944

CIRCULAR LETTER NO. 5

SUBJECT: Vesicant Chemical Casualties.

1. Recent surveys indicate that the standard of training in the care of gas casualties is not being maintained upon as high a level as is necessary. While chemical action has not been initiated, it remains a constant threat. Any lessening in our gas discipline, or in our degree of medical preparedness against such action, enhances the advantage of chemical attack to the enemy. A high degree of gas training and proficiency in first aid and treatment constitute our most potent bulwark against hostile chemical action.

2. From time to time, new developments in first aid and therapy are detailed by Circular Letters and these changes should be incorporated in unit training.

3. VESICANT CASUALTIES.

a. Vesicant agents continue to present the major problems to the medical service. Mustard, lewisite, and nitrogen mustard are the vesicant chemicals most feasible for use. Vesicant detector crayons, paints, and vapor kits should be familiar items to all medical officers and their use and interpretation well understood. Particular attention should be paid to nitrogen mustard (Appendix 1) because its lack of a striking characteristic odor necessitates indicator detection. It must be borne in mind that even the characteristic odors of mustard and lewisite might go unheeded in the course of action if their recognition is not so familiar that it is axiomatic.

b. Mixturesof vesicant agents would likely be encountered. The German product "Winterlost" is composed of 50% mustard and 50% crude phenyl dichlorarsine (PDA). This mixture is prepard so as to be useful at somewhat lower temperatures than plain mustard. Other mixtures are possible. The German product "Zahlost" is a thickened preparation of mustard in synthetic resins. It is viscic and sticks to clothing or skin. Its vesicant properties are only those of the mustard it contains.

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c. Mustard or other vesicant agents dissolved in oil present certain special problems in and about ports or harbors. Following harbor accidents, or as a prepared beach defense, mustard may be dissolved in oil floating on the surface of the water. Persons immersed or covered with this mustard in oil solution will sustain extensive burns if the contaminated oil is not rapidly removed. The burns will cover great areas and may involve the entire body surface, but the local

lesions will not be as deep or as severe as those caused by mustard alone. The principle danger in this type of casualty is from the large body surface burn. In addition, absorption of toxic agent will take place from the entire surface exposed.

4. FIRST AID.

a. To be most effective, first aid must be immediate. It should be performed by the individual soldier himself or by his buddy. The unit medical officers are responsible for the unit commander's being informed of the need for first aid instructions. Proper first aid procedures should be ingrained in the enlisted men.

b. An important point to stress in first aid is the prompt removal of any excess of vesicant from the skin, as absorption and tissue damage will continue as long as vesicant remains there. Liquid splashes should be blotted off, but not rubbed or spread. Any absorbent material will serve this purpose. A thickened mustard preparation may have to be scraped off with a knife or similar edged object. Mustard-in-oil solution is easily removed by swabbing with either liquid paraffin, liquid petrolatum, crude oil, or soap and water. Speed is of paramount importance in all of these procedures.

c. After the vesicant agent is removed, Protective Ointment (M-4) is applied to the contaminated area and rubbed in vigorously for 20 - 30 seconds. It is then removed and the procedure repeated two to three times, depending upon the amount of contamination. As Protective Ointment is, in itself, somewhat irritating, it should not be used after erythema or vesicle formation is present. Ideally, it should be used almost at once. Organic solvents may be used for mustard or lewisite; they are not useful for Zahlost preparations.

d. Contaminated portions of clothing must be removed or torn off to prevent vapor or liquid seeping through to cause vapor burns.

e. If the face is contaminated with droplets or spray of vesicant, first aid should be given to the face before the gas mask is applied, since any toxic agent under the mask will vaporize, thereby damaging the respiratory tract and the eyes.

f. Eye first aid for mustard or nitrogen mustard must be given very soon after contamination to be useful. Irrigation with canteen water is the treatment of choice at this time. For lewisite in the eye, M-1 Eye Solution or BAL Eye Ointment is effective. This also is satisfactory against mixtures containing lewisite or other arsenical agent. Definitive treatment of eye injuries should include complete atropinization, prevention of infection, local analgesia, and avoidance of eye bandages, as previously instructed.

g. Distinction should be made between acute conjunctival reactions, which cause great discomfort and disability but last only a few days, and actual vesicant injury to the cornea proper and the deeper eye structures. The conjunctival reaction is acute, dramatic, often severe, and temporarily disabling, but it leaves no sequellae or permanent damage. Corneal and deeper eye structure damage is far more serious, requiring much longer hospitalization, specialized ophthalmological care, and may be attended by permanent changes.

h. The gas mask will give complete protection to the respiratory tract against all vesicant agents and all mixtures, and the prevention of lesions is far more effective than their treatment. Upper respiratory tract lesions are painful and disabling; their therapy not remarkable. The danger to life is from secondary pulmonary infection. Prophylactic sulfadiazine administration is indicated, even in the face of significant systemic poisoning and leucopenia, if the lower respiratory tract has been involved.

5. BAL.

a. BAL (British Antilewisite) now is being prepared as an ointment for use in the eye. This will replace the medical item now known as M-1 Eye Solution. Each soldier will be provided with a small ophthalmological tube of BAL which he will carry in the same manner as Protective Ointment.

b. BAL is being prepared also as an ointment for skin use. BAL is a specific antidote for arsenical vesicants and will counter the systemic, as well as the local effects of lewisite. 8% H_2O_2, if used promptly, will counter only the local effects of lewisite on the skin. If BAL were not available, 8% H_2O_2 would be the best substitute.

c. The earlier BAL is used the greater will be its therapeutic effectiveness, but it should not be used unless there is, at least, a reasonable certainty that the vesicant is lewisite or a mixture containing an arsenical. BAL is somewhat toxic if absorbed in undue amounts in the absence of an arsenical. It should not be used indiscriminately, but, if employed within the amounts required by the degree of skin contamination, it will prove a most valuable treatment.

6. SYSTEMIC EFFECTS.

a. It should be remembered that, if large body areas are burned with vesicant agents, profound alterations of normal physiological systems will be induced just as if the injury were thermal. These changes will be related more to the extent of the skin lesion than to its severity. In extensive lesions, body fluid balance will be upset by loss of fluid into the skin and subcutaneous tissues, with a resultant hemoconcentration of varying degrees. This fluid loss is much more than that which shows as actual vesicle formation. The arterial blood pressure may fall, due to alterations in the peripheral vascular bed, and this fall in tension will be very difficult to combat. Changes in electrolyte balance and blood protein levels also will be dependant upon the size of the area burned. The clinical picture presented may be varied, depending upon the actual systemic poisoning that occurs from absorption of toxic agent, and the systemic changes induced by large skin areas of body surface that have been burned. Small surface areas may show no such changes; large area burns may demonstrate very severe and significant effects.

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b. Arsenical poisoning will accompany absorption of lewisite or of mixtures containing organic arsenicals. This poisoning may be averted by prompt use of BAL. Except for the use of BAL, there is no change in the method of treating arsenical poisoning.

c. If large amounts of mustard are absorbed, systemic effects may be produced in addition to such changes as are attributable to surface burn. There may be a depression of lymphopoesis and granulopoesis of severe degree, and liver damage may be sustained in fatal cases. Treatment is supportive during the acute phase, which may last about one week.

d. Nitrogen mustard therapy is indicated in appendix attached.

7. RECORDS.

a. The accurate recording of observations and data will be most important in the days immediately following a hostile chemical attack. The pattern of any new combination of agents can be rapidly revealed only if multiple accurate observations are recorded as made. With this in mind, the importance of adequate records should be stressed repeatedly.

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

DISTRIBUTION:

All Medical Officers	
Surgeon, LBS	- 400
Surgeon, IBS	- 300
Surgeon, ABS	- 150
Surgeon, IBS	- 100
Surgeon, PBS	- 500
Surgeon, NORBS	- 100
Surgeon, AMGOT	- 25
Surgeon, CD IBS	- 50
Surgeon, Fifth Army	- 600
Surgeon, Seventh Army	- 350
Surgeon, AAF, MTO	- 50
Surgeon, 12th Air Force	- 300
Surgeon, 15th Air Force	- 300
Surgeon, AAFSC, MTO	- 200
Surgeon, Hq. Command, AF	- 50
Surgeon, NATOUSA	- 200

APPENDIX 1

NITROGEN MUSTARD

1. PROPERTIES.

Nitrogen mustard is a persistent vesicant agent with a significant systemic poisoning effect. In field concentrations, it has only a faint odor, described as soapy or fishy. Odor alone can not be relied upon in detecting nitrogen mustard, and detector aids (paper, crayon, paint, and vapor kits) must be employed. The agent hydrolyzes and polymerizes fairly readily in water and is rendered non-vesicant but not nontoxic by such action. The service gas mask, when worn, gives complete protection to the eyes and lungs. Goggles and eye shields will protect from spray droplets but not from vapor. Impregnated clothing offers some protection. Nitrogen mustard readily penetrates surgical rubber gloves.

2. PHYSIOLOGICAL EFFECTS.

a. Eyes. Liquid and vapor will produce casualties from very low concentrations. There is an initial acute conjunctival reaction. Corneal denuding, infiltration, and clouding are followed by an iridocyclitis. Symptoms of lacrimation, pain, burning, and fogging of vision may progress to temporary loss of vision due to blepharospasm. Damage usually is not permanent or total and considerable progress toward recovery will take place if secondary infections are prevented or controlled.

b. Skin. Liquid or vapor will produce burns and blisters, but their appearance may be delayed up to 24 hours. The blister is translucent, has sloping sides and is surrounded by a zone or erythema. Nitrogen mustard is not as powerful a skin vesicant as mustard.

c. Respiratory Tract. The lining of the respiratory tract is damaged by vapor in a manner very similar to that caused by mustard vapor. There is marked swelling, erythema, and, later, necrosis of the nose, larynx, and trachea. Descending respiratory tract infection and severe suppurative pneumonitis are common if there has been a significant exposure to vapor, and often are complicated by empyema. Oedema of the lungs is uncommon but may follow exposure to high concentrations of the agent.

d. Systemic Effects. A parasympathetic system action is evidenced by salivation, lacrymation, bloodless diarrhea, and abdominal cramps. Central nervous system changes are manifested by muscular tonus changes, leading to convulsive seizures, or, at times, flaccid paralysis. Pathological changes have been described in the basal ganglia. The hematopoietic and lymphogenic centers are depressed, causing a severe leucopenia, at times approaching aleukemia. The red blood cells are little affected. The mechanism of death is not certainly known, but systemic poisoning can occur from skin absorption.

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3. FIRST AID AND TREATMENT.

a. Skin. All of the agent should be blotted from contaminated skin areas. Protective ointment then should be used for other vesicant agents.

As the ointment merely dilutes nitrogen mustard, it is necessary to wash off the film of ointment with soap and water, when possible. Greater reliance should be put on washing, even with plain water, if only nitrogen mustard is the contaminant.

b. Eyes. Immediate copious irrigation with water should be made if the lesion is due to liquid splash, but not if the lesion is due to vapor. The eyes should be atropinized and the pupils kept well dilated until recovery occurs. Local analgesics, except cocaine, may be used. The eyes should not be bandaged. Sodium sulfacyl solution should be used to prevent or control infection.

c. Respiratory Tract. Appropriate symptomatic treatment is indicated for local upper respiratory tract lesions. Sulfadiazine should be given by mouth in full dosage to prevent or control secondary pneumonitis. Isolation is desirable if at all possible. Convalescence will be prolonged, and empyema must be watched for carefully.

d. Systemic Effects. Sodium thiosulphate solution, if given early, may abort systemic effects. 100 cc of 10% sodium thiosulphate may be given intravenously. To be effective, this should be given within a few hours after exposure, preferably within one hour. Atropine will control the diarrhea, salivation, and abdominal cramps. Doses of 1/100 gr or 1/150 gr should be employed, and repeated as needed until a therapeutic effect is achieved. Barbiturates should be used, if necessary. Adequate vitamin intake, supplemented by liver extract, may help improve the blood picture. Stimulants of the leucopoetic system are indicated but their value is problematical. Small transfusions of fresh whole blood may be of some benefit. General symptomatic treatment should be instituted as indicated.

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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

~~Surg AMGOT~~ Sick

18 January 1944

CIRCULAR LETTER NO. 4

SUBJECT: Disposition of individuals with neuropsychiatric disorders.

1. At the present time over 45 percent of the certificate of disability discharges are for neuropsychiatric reasons. The importance of eliminating actual or potential neuropsychiatric noneffectives has not diminished. The possibility must be considered, however, that neuropsychiatric criteria for service are now being interpreted too strictly and that men are being separated from the service who could be of value were they retained.

2. Because of the nature of the problem, no rigid criteria for disposition can be followed. Each case must be evaluated individually and disposition made on the basis of clinical judgement as to the individual's potential value to the service.

3. A man will not be separated from the service merely because he has or has had a psychoneurosis or similar psychiatric disorder. It is well established that a large proportion of men developing these disorders, particularly in combat zones, if properly treated and promptly returned to duty, recover entirely and render valuable service.

4. Decision as to an individual's potential value to the service should rest on the fundamental soundness of his personality rather than on the symptoms from which he is suffering at the moment. Anyone, no matter how sound his personality, may develop a psychiatric disorder under certain circumstances and will recover, if properly treated, when these circumstances are changed or when he has had an opportunity to adjust to them. In each case there should be an attempt to determine whether the psychiatric disorder is merely the natural result of fatigue, misassignment, a distressing situation, or whether it is a manifestation of a fundamental neuropsychiatric unsuitability for military service. 3721

5. Where the psychiatric disorder is believed to arise more from indifference toward the war than from fundamental instability of personality, the individual will be retained for service.

6. It has come to the attention of this office on repeated occasions that individuals have been recommended for discharge under the provisions of section VIII, AR 615-360, merely on the basis of a low mental age without apparent regard for his usefulness to the service. Any intelligence test must be used solely as

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A-C (1)
Reg I (3)
Reg II (3)

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an aid to a diagnosis and not as an end in itself. Every effort will be made to determine the soldier's ability to render effective service to the Army before considering any such recommendation.

7. Disposition of neuropsychiatric cases may be any of the three following:

a. To full duty. Individuals who, after careful study by examining medical officers, are believed to be of potential value at full duty in combat zones regardless of the psychiatric diagnosis which has been made, will be returned to duty.

b. To duty of less arduous nature than full duty in combat zones. Individuals who, after careful study by medical officers, are believed to be noneffective for combat duty but potentially capable of serving in less arduous assignment, either in continental United States or overseas, will be returned to duty with a recommendation to this effect.

c. Separation from the service.

(1) Individuals who, after careful study, are believed to be of no further value to the service because of the presence of psychosis, psychoneurosis, epilepsy, or organic neurologic disease, will be separated from the service under the provisions of sec. II, AR 615-360.

(2) Individuals who, after careful study, are believed to be of no further value to the service because of the presence of mental deficiency, psychopathic personality, or primary behavior disorders (such as chronic alcoholism, drug addiction, etc.) will be discharged under the provisions of section VIII, AR 615-360.

8. It is to be understood that "physical standards" or similar terms include nervous and mental conditions when used in Army Regulations and other War Department publications pertaining to medical matters.

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

DISTRIBUTION:

Surgeon, AAF, MTO	- 50
Surgeon, 12th Air Force	- 300
Surgeon, 15th Air Force	- 300
Surgeon, AAFSC, MTO	- 200
Surgeon, LBS	- 400
Surgeon, MBS	- 300
Surgeon, ABS	- 150
Surgeon, IBS	- 100
Surgeon, PBS	- 500
Surgeon, NBS	- 100
Surgeon, ANGOT	- 25
Surgeon, CD NBS	- 50
Surgeon, Seventh Army	- 350
Surgeon, Fifth Army	- 600
Surgeon, Hq. Command, AF	- 50
Surgeon, NATOUSA	- 200

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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

10 January 1944

CIRCULAR LETTER NO. 3

SUBJECT: Report of Dental Service, M.D. Form 57.

1. A Report of Dental Service, M.D. Form 57, is required from every military station and separate command where a dental officer has been on duty during the month. It will be signed by the dental surgeon. This report, including a copy for the dental surgeon in the next higher headquarters, will be forwarded through medical channels before the fifth day of the next succeeding month. Army and Base Section dental surgeons will consolidate reports received and will forward same, with original copies of organizational reports, to the Surgeon, NATOUSA, at the earliest practical date. These will be forwarded with a letter of transmittal listing organizations covered by the consolidated report. The consolidated report will not list officer personnel in section 5a as required for organizational reports.

2. Preparation of report.

a. Section 1. Enter station or command with strength and APO number. Location need not be given.

b. Section 2. Enter the calendar month or the beginning and end of period if less than the calendar month. If the period is less than a month but extending into a second month, as an example, from 20 June to 3 July, two reports mustbe made out and forwarded, one from 20 June to 30 June and another from 1 July to 3 July.

3720

c. Section 3. General Summary of Dental Service.

(1) Admissions. Record total of military personnel admitted for routine admissions for month, and record total of military personnel admitted for relief of pain or other intolerable conditions as emergency admissions for the calendar month. The same procedure is followed with others entitled to treatment, as well as with prisoners of war. Separate entries will be made for military personnel, prisoners of war, and others.

A patient may be admitted but once. If a patient is not completed during one calendar month, he is not recorded as an admission for the following month. If the appointments for a patient are discontinued, interrupted, or postponed for an indefinite period and he later returns for further treatment, it may be recorded as a new admission at the discretion of the dental officer concerned, who will be governed by the elapsed time and circumstances of the case.

(2) Sittings given. Each visit of a patient to a dental clinic for treatment is considered a sitting. Sittings for the purpose of examination should be recorded.

d. Section 4. Classification of Military Personnel. Enter the classification of the command from last survey if a survey has been taken during the month, or modify the survey figures in subsequent months by estimating changes in classification by reviewing the number of patients called for treatment from survey lists.

e. Section 5. Duty Personnel.

(1) Officer personnel. Officers' names, rank, and duty will be recorded in 5a.

(2) Other personnel. Report only the number of enlisted men of each grade on duty with the dental service which includes those attached from other units. Civilian employees will also be recorded by occupation.

(3) Summary. Separate listings will be made for the number of dental officers assigned, attached, or otherwise present for duty.

The total days of duty is the combined total of assigned, attached, and others, including Sundays and holidays.

The total number of days not present for duty, such as sick leave, assigned for other duty, etc., will be placed directly under the heading, "total days of duty".

f. Section 6. Cases Diagnosed; and Section 7. Operations Performed.

(1) General. The standard terms for diagnoses will be used insofar as practical in accordance with AR 40-1010, 16 October 1943. The data for this section is obtained from the individual M.D. Forms 79. While a diagnosis should be entered for each operation, not all entries in the operations section need corresponding diagnoses in section 6. No exact balance between sections 6 and 7 is desirable or required; however, the operations should be prepared for the diagnosed cases in accordance with good professional practice. In other words, when a tooth is extracted, the diagnosis entered should indicate that extraction was the

proper treatment and no definitive dentistry could have restored the tooth. Caries, therefore, is not the proper diagnosis for extraction; pulpitis, abscess periapical, tooth impacted, or some other applicable diagnosis should be entered.

(2) Prosthetics.

(a) The diagnosis maxillae edentulous or mandible edentulous will be made only when a full upper or a full lower denture has been completed and inserted. Full dentures under section 7 should be balanced by the total of maxillae and mandible edentulous under section 6. The diagnosis missing teeth should be used for reporting bridges and partial dentures and the corresponding number of missing teeth should appear on the same report as the appliance. The actual number of teeth replaced by bridges and partial dentures (not the number of natural teeth replaced) will be placed opposite diagnosis, "tooth missing" in section 6. The diagnosis is not entered when the prosthesis is started but only when completed and inserted.

(b) When a station takes an impression, completes the laboratory work, and then sends the dentures to another station or command for insertion, the station or command actually inserting the denture will take credit under sections 6 and 7. The station taking the impression and completing the laboratory work will cite such accomplishments only under section 8, General Remarks. Credit may also be taken for a sitting by the station taking the impression.

(c) Credit for denture adjustments will not be taken on cases which were initiated at your station unless the dentures have been in use several months. Credit for adjustments may be taken on cases which were made in civilian practice or at another station. Credit may be taken for sittings for denture adjustments on all cases, and the diagnosis on M.D. Form 79 should be shown as "Reappointment" for cases initiated at your station. Diagnoses for cases made in civilian practice or at another station should be "Denture defective".

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(3) When dental service for prisoners of war is reported, the column "others" will be divided and all such work listed.

g. Section 8. General Remarks.

(1) Reference should be made to inadequacies of personnel or equipment or any other conditions which interfered with the maximum of professional dental service being performed for the period.

(2) Permanent transfers of officers will be shown stating date of transfer and organization to which transfer was made.

3. The following are herewith rescinded.

a. Circular Letter No. 22, Office of the Surgeon, Hq. NATOUSA, 26 June 1943.

b. Par. 1, Circular Letter No. 33, Office of the Surgeon, Hq. NATOUSA, 9 September 1943.

c. Par. 1, Section XIII, Circular Letter No. 39, Office of the Surgeon, Hq. NATOUSA, 7 October 1943.

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

DISTRIBUTION:

Surgeon, EBS	- 400
Surgeon, MBS	- 300
Surgeon, ABS	- 150
Surgeon, IBS	- 100
Surgeon, PBS	- 500
Surgeon, ANGOT	- 25
Surgeon, CD, MBS	- 50
Surgeon, Seventh Army	- 350
Surgeon, Fifth Army	- 600
Surgeon, Hq, Command, AF	- 50
Surgeon, AAF, MTO	- 50
Surgeon, Twelfth Air Force	- 300
Surgeon, Fifteenth Air Force	- 300
Surgeon, AAFSC, MTO	- 200

Dist: Med C. (2)
Hq Comd (1)
A-G (1)
Req I (3)
Req II (3)
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HEADQUARTERS
NORTH AFRICAN THEATER OF OPERATIONS
Office of the Surgeon
APO 534

6 January 1944.

CIRCULAR LETTER NO. 2

SUBJECT: Medical Care of Foreign Personnel.

1. All previous instructions from this office on the preparation and submission of Nominal Rolls for medical care of foreign personnel are hereby rescinded.

2. In compliance with instructions from the War Department, the following procedure for rendition of reports concerning such medical care is directed.

a. Commanding officers of all hospitals will render monthly reports to the Surgeon General, U. S. Army, Washington 25, D.C., through medical channels of all foreign personnel cases hospitalized as per attached form, marked Exhibit "A". These reports will be submitted in quadruplicate (one (1) original and three (3) clear carbon).

3. The Nominal Rolls previously forwarded to Base Section Surgeons for action as indicated in Administrative Memorandum No. 12, Hq. NATOUSA, 19 September 1943, will be sent to this office for transmittal to the Surgeon General.

For the SURGEON:

E. STANDLEE,
Colonel, M.C.,
Deputy Surgeon.

1 Incl:- Exhibit "A".

DISTRIBUTION: All Hospitals.
Surgeon, AAF, MTO - 50
Surgeon, Twelfth Air Force - 50
Surgeon, Fifteenth Air Force - 50
Surgeon, AAFSC, MTO - 50
Surgeon, BBS - 75
Surgeon, BBS - 50
Surgeon, ABS - 50
Surgeon, IBS - 50
Surgeon, PBS - 75
Surgeon, ANCOT - 25
Surgeon, CD MBS - 25
Surgeon, Seventh Army - 50
Surgeon, Fifth Army - 75
Surgeon, Hq. Command, AF - 25
Surgeon, NATOUSA - 75

3718

CONFIDENTIAL

STATION HOSPITAL

3717

Report of HOSPITALIZATION of authorized foreign personnel for the month of _____ 1944

Name in full	Authorized Personnel (country)	Rank	Organization	Inclusive dates of Hospitalization	Number Patient Days	Diagnosis
Smith, John Henry	England	Captain	Staff Hqrs. Wash., D.C.	7-5--7-11	7	Tonsillitis, chronic follicular, bilateral
Bell, Jay Henry	Canada	Corporal	RCAF	7-5--7-31	27	Sclerosis, multiple.
					34	

I certify that the foregoing statement is correct.

(To be signed by the commanding officer of the hospital)

EXHIBIT "A"

CONFIDENTIAL